Columbus

REQUEST FOR CERTIFICATION OF AMERICANS WITH DISABILITIES ACT (ADA) PARATRANSIT ELIGIBILITY

The information obtained in this certification process will only be used by the City of Columbus for the provision of transportation services. Information regarding the evaluation of your functional ability to use transit services will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Name _____

2. Address _____

_____

State _____ Zip _____

3. Telephone Number (Home) _____ (Work) _____

4. Date of Birth ____/____/____

5. What is the disability which prevents you from using our fixed route service?

_____

_____

Is this condition temporary? _____ If Yes, expected duration until ____/____/____

6. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed. _____

_____

_____

_____

_____

7. Are there any other effects of your disability of which we need to be aware?

_____

_____

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY THE CITY OF COLUMBUS.

8. Do you use any of the following aids to mobility? (Check all that apply)
Manual wheelchair ___ Electric wheelchair ___ Powered scooter ___
Cane ___ Crutches ___ Personal care attendant ___ Guide dog ___
Other service animal (Describe) _____

If you use a wheelchair or scooter, what is its:
Length _____inches Width _____inches

Does the total weight of your wheelchair/scooter and yourself exceed 600 pounds? Yes_____ No _____

9. Do you currently use any transit or paratransit service in the region?
Yes ____ No ____ (Please describe the services you use) _____
_____

10. Please answer the following questions:
What is the maximum distance you can travel without assistance of another person? _____yards
(For reference: 1/4 mile = 440 yards; 1/2 mile = 880 yards; 3/4 mile = 1320 yards).

Does your disability prevent you from travelling this distance in snow, ice, or over certain terrain? (Explain)
_____
_____

Can you climb up and down three 12 inch steps to get on and off of a bus?
Yes ____ No ____ Sometimes ____

What is the maximum period you can wait outside without support?
_____minutes

Is this time period affected by extremes of hot or cold weather?
Yes ____ No ____ (If Yes, please describe your situation below)
_____
_____

11. I hereby certify that the information given above is correct.

Signed _____ Date___/___/___

12. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____

Address _____

_____State _____Zip_____

Daytime Phone _____

Signed _____ Date ___/___/___

In order to allow the City of Columbus to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.

Please identify the professional best able to verify your functional ability to use transit services. For example, if you use a mobility aid or are physically unable to get to or from a bus stop or on a bus, identify, if possible, a rehabilitation counselor, independent living counselor, occupational therapist, or other such professional knowledgeable of your functional abilities. If you have a cardiac condition, pulmonary condition, visual impairment, or temperature sensitivity, identify a physician or health care professional with the appropriate specialty to provide information about your condition. If you have a cognitive or developmental disability, identify, if possible, an independent living counselor or other social service professional familiar with your capabilities.

The following Rehabilitation Counselor ____; Independent Living Counselor ____; Occupational Therapist ____; Social Service Professional ____; Physician ____; Health Care Professional ____ (check one) is familiar with my disability and is authorized to provide information to the City of Columbus required to complete this certification.

Name _____

Address _____

_____

State _____ Zip _____

Phone Number _____

Print Name _____ Date of Birth ___/___/___

Signed _____ Date ___/___/___